Coastal Psychiatry
Ryan W. Ingram, M.D.

New Patient Information

Name _____ Date _____

DOB _____ SSN _____ Marital status: **S / M / D / W**

Address _____

Email address _____ Okay to use? **Y / N**

Home phone _____ Okay to leave messages? .....**Y / N**

Work phone _____ ..... **Y / N**

Cell phone _____ ..... **Y / N**

How would you like to be reminded of your appointments? ☐ phone ☐ text ☐ email

Occupation _____ Hours worked per week? _____

Employer (name of school if student) _____

Health insurance _____ Prescription coverage? **Y / N**

EMERGENCY CONTACT INFORMATION:

Name_____ Relationship _____

Address _____

Home ph _____ Cell ph _____ Work ph _____

IF ANOTHER PERSON IS RESPONSIBLE FOR CHARGES:

Name _____

Address _____

Home ph _____ Cell ph _____ Work ph _____

How did you hear about Coastal Psychiatry? _____

What is your reason for making an appointment? _____

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www.coastalpsychvb.com

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Medical History

Name _____ Date _____

Primary Care Provider ☐ Check box if none

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Date of last visit _____ Frequency of visits _____

Current/Former Therapist ☐ Check box if none

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Date of last visit _____ Frequency of visits _____

Current/Former Psychiatrist ☐ Check box if none

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Date of last visit _____ Frequency of visits _____

Current Medications (include nutritional supplements, herbal supplements, and over-the-counter medications)

Name of medication	Dose	Frequency	Reason prescribed	Approximate start date

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Medical History (cont.)

Name _____ Date _____

Allergies (medication or food) _____

☐ Check box if no known allergies

Do you smoke? Y N If yes, how much and for how long? _____
Do you drink? Y N If yes, how much and for how long? _____
Any past or present substance abuse (prescription or illicits)? Y N If yes, how much and for how long?
_____

SPECIALISTS SEEN (AT ANY POINT IN THE PAST): ☐ CHECK BOX IF NONE

__allergist
__cardiologist
__cardiothoracic surgeon
__dermatologist
__ear, nose, throat specialist
__endocrinologist
__gastroenterologist
__general surgeon
__hematologist
__infectious disease specialist
__nephrologist
__neurologist
__neurosurgeon
__oncologist
__orthopedic surgeon
__pain specialist
__plastic surgeon
__pulmonologist
__rheumatologist
__urologist
__sleep specialist
__OB/Gyn (other than routine)
__opthalmologist (other than routine)
__internist (other than routine)
__OTHER_____

HAVE YOU EVER HAD: ☐ CHECK BOX IF NONE

__seizures
__blackouts
__fainting spells
__heart palpitations
__chest pain
__shortness of breath/asthma
__fracture or severe injury
__head injury/concussion

MEDICAL CONDITIONS:

_____ _____ _____
_____ _____ _____

HOSPITALIZATIONS, SURGERIES, EMERGENCY ROOM VISITS (PLEASE INCLUDE DATES):

_____
_____

PAST SUBSTANCE ABUSE TREATMENT (INPATIENT, OUTPATIENT, NA/AA):

_____
_____

PAST PSYCHIATRIC MEDICATIONS AND RESPONSE TO MEDICATION:

_____
_____

FAMILY PSYCHIATRIC HISTORY:

_____
_____

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Seeing patients at Coastal Psychiatry without the restrictions of insurance companies allows Dr. Ingram to see fewer patients and devote more time to each case, thereby delivering what we consider to be higher quality health care. Frequency of appointments will be tailored to each patient's specific needs. The expected course of treatment will be discussed at the initial visit.

Initial psychiatric evaluation (60-120 minutes) $260
Medication management with brief psychotherapy "Half Session" (30 minutes) $130
Medication management with psychotherapy "Full Session" (50-60+ minutes) $180
Couples/family session (60-90+ minutes) $220

FMLA or Disability paperwork $35

Payment is due in full at time of service. We accept cash, debit cards, and all major credit cards. **We do not accept checks.** We will be happy to provide a billing statement for you to submit to your insurance company. You can check with your insurance carrier for out-of-network mental health benefits or preauthorization requirements prior to making an appointment to determine your possible reimbursement.

Appointments are available on Mondays, Wednesdays, and Fridays. Same day appointments can be accommodated if space is available.

Court Deposition Fee Schedule

Dr. Ingram is available to testify in a legal deposition on your behalf as a fact witness. The testimony is limited to your care solely at Coastal Psychiatry and carries a separate fee schedule and contract.

A deposition that includes a review of depositions, records from other providers not already in the chart or other materials and renders opinions is an Expert Witness Examination, which also carries a different fee schedule and contract.

Fact Witness and Expert Witness Examination fee schedules and contracts can be furnished upon request.

Returned Check Fee

Checks returned by the bank will be charged a $35 returned check fee.

Cancellation Policy

We understand that situations may arise in which you will not be able to keep an appointment. Should you have to cancel or reschedule please give two (2) business days' notice. No-show or appointments not cancelled with two (2) business days' notice are subject to a $50 charge.

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Medication and Refill Policy

In order to effectively manage your medication, please be aware that the following guidelines need to be followed:

1. To receive refills of your medication(s), you must make an appointment to see Dr. Ingram in person for a 30- or 50-minute session at least every 3 months. **This minimum frequency tends to vary based on the medication(s) prescribed and stability of the patient.**
2. Please notify Dr. Ingram or his nurse immediately of any side effects of your medication.
3. Please notify Dr. Ingram or his nurse any time another physician starts or changes your medication or there is a change in your health status. This is important as certain medications or illnesses can alter the effect of the prescribed medications and adjustments may need to be made.
4. Please anticipate any refill needs and discuss it during the office visit. Refills cannot be done on weekends or holidays.
5. Pharmacies can fax refill requests to **757.368.2002**.
6. Requests for refills may take up to 48 hours to be available at your pharmacy.

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Limits of confidentiality

Dr. Ingram values and respects the privacy of the patient and considers all therapy sessions to be confidential. Both verbal information and written records about the patient cannot be shared with another party without written consent of the patient or patient's legal guardian. The following are exceptions to this confidentiality as outlined by the American Psychiatric Association:

Duty to Warn and Protect

When there is good reason to believe an individual is threatening serious bodily harm another person, Dr. Ingram is required to warn the intended victim and report this information to authorities. In cases which an individual discloses or implies a plan for suicide, Dr. Ingram is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

Abuse of Children and Vulnerable Adults

If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, Dr. Ingram is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Dr. Ingram is required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor patients have the right to access the patients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to patients. Information that may be requested includes types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. ***Please note that since Coastal Psychiatry in an out-of-network provider, communication with insurance providers will have been initiated by patient and patient will sign release of information before any information is given to third-party payers.***

Other limits of confidentiality

In response to a court order, or where otherwise required by law.
To the extent necessary to make a claim on a delinquent account via a collection agency.
To the extent necessary for emergency medical care to be rendered.

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Patient Consent

Please initial:

_____Confidentiality
I have read and understand the privacy practices for Coastal Psychiatry, P.C. I have received the HIPAA information. If I have any questions at any time, I will bring them to the attention of Dr. Ryan W. Ingram.

_____Limits of Confidentiality
I agree to the limits of confidentiality and understand their meanings and ramifications. I understand that if I choose to file claims with insurance, Coastal Psychiatry, P.C. will provide necessary information about my services rendered and fees collected.

_____Cancellation Agreement
I agree to be financially responsible for missed or cancelled appointments with notice less than 24 hours.

_____Fee Schedule
I agree to and understand the fee schedule for services rendered by Dr. Ryan W. Ingram at Coastal Psychiatry, P.C. I acknowledge that the fees incurred for professional services of Dr. Ryan W. Ingram at Coastal Psychiatry are my sole responsibility and payable at the time of service. I agree and understand that legal depositions follow a separate fee schedule, which will be provided in a separate contract if those services are needed.

_____Medication and Refill Policy
I agree to and understand the medication and refill policy.

Consent to Treat

I, _____, have read the policies and procedures of Coastal Psychiatry and give Dr. Ryan W. Ingram consent for evaluation and treatment.

_____ _____
Patient's name Date

_____
Name of Parent or guardian of minor patient and relationship to patient

_____
Signature of patient (Parent or guardian if patient is under 18)

_____
Signature of Dr. Ryan W. Ingram

_____
Witness

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Notice of Privacy Acts

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended from time to time.

Our Responsibilities

We understand that information about you and your health is personal and sensitive in nature. We are committed to protecting the privacy of this information. Our primary responsibility for your personal health information is to keep it safe. We must also give you this notice of privacy practices, and we must follow the terms of the notice.

Protected Health Information

Protected Health Information (PHI) is demographic and individually identifiable health information that will or may identify the patient and related to the patient's past, present, or future physical or mental health or condition and related health care services.

Medical Information

At Coastal Psychiatry, your medical records are used as a way of recording health information, planning care and treatment and as a tool for routing health care operations. If insurance companies are involved in reimbursing for payments for services, they may request information such as procedure and diagnostic information. Information that may identify you will not be released to anyone without written authorization from you or your parent or legal guardian.

Medical information may be used to justify patient care services (i.e. lab tests, prescriptions). We will use medical information to establish a treatment plan. We may use the emergency contact information you provided to contact you if the address if record is no longer accurate. We may contact you to remind you of the your appointment by phone, text, or email. We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.

Minors-If you are an unemancipated minor under Virginia law, there may be circumstances in which we disclose health information about you to a parent or guardian in accordance with legal and ethical responsibilities.

Parents-If you are a parent or guardian of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances.

Patient Rights

As a patient at Coastal Psychiatry, you have the right to:

- **Request a restriction on certain uses of your protected health information.** We are not required by law to agree to your request.
- **Obtain a paper copy of this Notice of Privacy Practices upon request.** You may ask us to restrict or limit the medical information we use or disclose for the purposes of treatment, payment, or healthcare operations. We are not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment or required by law.
- **Inspect and request a copy of your protected health information for a fee.** This includes medical and billing records and any other records that we use in making decisions about your healthcare. This does not include however, psychotherapy and psychosocial notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Please contact Marie DelosSantos if you have any questions about access to your medical records.
- **Request an amendment to your health record** if you feel the information is incorrect or incomplete. We may deny your request for an amendment if:
    - it is not in writing,
    - it does not include a reason to support the request,
    - the information was not created by our practice,
    - it is not part of the information kept by our practice,
    - it is not part of the information which you would be permitted to inspect and copy,
    - the information already in the record is accurate and complete.

Please note that even if we accept your request, we are not required to delete any information from your health record. If we disagree with your request you have the right to submit a statement of disagreement to be enclosed with future releases of the information in question.

- **Obtain a record of the sharing/disclosures of your health information.** The record will only list information shared for purposes other than treatment, payment or healthcare operations and will exclude information that was shared because of a valid authorization.

- **Request communication of your health information by alternative means or to alternative locations.** We will honor reasonable requests when you provide the alternative address/contact information and information on how payment will be handled.
- **Revoke your authorization** to use or share health information except to the extent that action has already been taken. To revoke or cancel this authorization, you must submit your request in writing to Coastal Psychiatry.
- **Understand your rights.** Tell Dr. Ingram if you don't understand this authorization. He or his office staff will gladly explain it to you.
- **Refuse to sign this authorization**. Your refusal will not affect your ability to obtain treatment. If you refuse to sign this authorization Dr. Ingram and Coastal Psychiatry has the right to decide not to treat you or accept you as a patient in the practice.

Disclosure of psychotherapy notes.
HIPAA provides special protections to certain medical records know as "Psychotherapy Notes." All psychotherapy notes recorded on any medium (i.e. paper, electronic) by the physician must be kept by the author and filed separate from the rest of the patient's medical records to maintain a higher standard of protection. HIPAA defines "Psychotherapy Notes" as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Written authorization is required by the patient to specifically allow for the release of the Psychotherapy notes to a third party.

I understand I have the right to review Coastal Psychiatry, P.C.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Coastal Psychiatry, P.C. The Notice of Privacy Practices for Coastal Psychiatry, P.C. is also provided on the Coastal Psychiatry, P.C. website at www.coastalpsychvb.com. The Notice of Privacy Practices also describes my rights and the duties of Coastal Psychiatry, P.C. with respect to my protected health information. Coastal Psychiatry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by accessing the Coastal Psychiatry website, calling the office and requesting a revised copy be sent by mail, or asking for one at the time of my next appointment. A copy of the current notice will also be posted in the practice.

_____ _____
Patient's name (parent or legal guardian if patient is under 18) Date

_____
Relationship to patient

_____
Signature of patient (parent or legal guardian if patient is under 18)